Healthy You for Life Program

Physician Prescription Form

PATIENT'S NAME____Age __________DOB___________

Parent/Guardian name____________________________________Parent's DOB _________________

Phone #_________________________Cell ______________________ Work _______________________

Mailing Address ____

Weight _______Height_______BMI%______ Male / Female Race_____

How much weight has this patient gained over the past year? _____

DIAGNOSIS (please check all that apply)

	Diagnosis	Code		Diagnosis	Code		Diagnosis	Code
____	Abnormal Weight Gain	783.1	____	Acanthosis Nigricans	701.2	____	Depressive D.O. NOS	311
____	BMI >85 - <95	V85.53	____	Hypertriglyceridemia	272.1	____	Anxiety D.O. NOS	300.0
____	BMI >95	V85.54	____	Impaired Glucose Tolerance Test	790.22	____	ADHD NOS	314.9
____	Dysmetabolic Syndrome	277.7	____	Obstructive Sleep Apnea	327.23			
____	Hypercholesterolemia	272.0	____	Sleep Apnea	780.57	____	Hypertension	401.9
____	Hyperlipidemia	272.2	____	Sleep Disturbance	780.5	____	Elevated Blood Pressure	796.2
____	Hypertriglyceridemia	272.1	____	Snoring	786.09			
____	Essential Hypertension	401.0	____	Asthma	493.00 493.92	____	Hip Joint Pain	719.45
						____	Pes Planus (Flat Foot)	734
____	Gastroesophegeal Reflux	530.81	____	Urinary Incontinence	788.39	____	Knee Joint Pain	719.46
____	Elevated LFTs	790.6	____	Amenorrhea	626	____	Ankle/Foot Joint Pain	719.47
____	Steatohepatitis	571.8	____	Oligomenorrhea	526.1	____	Low Back Pain	724.2
			____	Gynecomastia	611.1	____	Exercise Intolerance	V69.9

____ Other ____

LABS DONE WITHIN 6 MONTHS - YES or NO @ CHKD, @ SENTARA, or OTHER ____________

Primary Insurance Company ____

Name of Policy Holder ____DOB _______________________

Subscriber # ________________________________ Group # _______________________________________

Relationship to Subscriber ____

Secondary Insurance Company ____

Name of Policy Holder ____DOB _______________________

Subscriber # ________________________________ Group # _______________________________________

Relationship to Subscriber ____

If insurance referral is required by patient's insurance provider, REFERRING physician is responsible for obtaining the referral from insurance company. AUTHORIZATION #________

The patient will be evaluated by the Healthy You for Life team including:

• The Healthy You Physician • Registered Dietitian• Physical Therapist • Licensed Clinical Social Worker

____Date______________

Physician's signature / Date *I certify that the services listed above are all medically necessary.*

____ /______________________________________

Physician's phone number and name PRINTED Name of Physician Practice

This form may be **FAXED to 668-7809** or mailed with the program registration form.

If you have questions, please contact Babs Benson, RN at 668-7035.